



Patient Application for Care

Willow Bend Chiropractic & Spinal Decompression Center

Patient Information

Name: (First Last)		Today's Date:		Birth Date: (MM/DD/YY)	
Street Address:			City:		State:
					Zip Code:
Height:	Weight:	Email Address:		Phone:	
Place of Employment:				Job Description:	

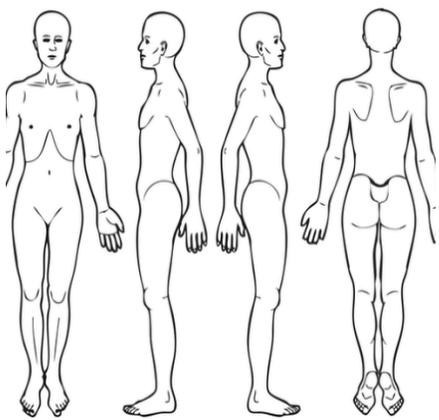
What brought you in today?

What problems or symptoms motivated you to visit us today? Please explain.

Even though you are not a spinal specialist, you are the person who knows more about your body than anyone else. In your own words and your own opinion, what do you think the real problem is?

Since your pain became severe, what **3** things have you missed the most because of it?

1. _____ 2. _____ 3. _____

<p>Please mark the area(s) of pain below</p> 	<p>How long has the problem been like this? _____</p>	<p>What activities are you limited in doing? _____</p>
	<p>How has your life changed since this became a problem? _____</p>	
	<p>What kinds of treatments have you received?</p> <p>Physical Therapy (HowLong?) _____ When (approx) _____</p> <p>Medication _____ When (approx) _____</p> <p>Surgery (Type?) _____ When (approx) _____</p> <p>Other _____</p>	
	<p>Did any of these treatments work? If so, which one? For how long? _____</p>	<p>Have you become tolerant of the pain?</p> <p style="text-align: center;">Yes No</p>
<p>What activities/movements are guaranteed to make it worse? _____</p>	<p>Is there anything that you do that makes it better? _____</p>	<p>Is it worse in the morning or is it worse as the day progresses? _____</p>
<p>On a scale of 1-10, (1= Mild & 10= Very Bad) Where would you rank your discomfort <u>RIGHT NOW?</u></p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>	<p>On a scale of 1-10, Where would you rank your discomfort <u>ON AVERAGE?</u></p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>	<p>On a scale of 1-10, Where would you rank your discomfort <u>AT ITS WORST?</u></p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>

Would you consider this problem (circle one)...

MINIMAL	(Annoying, but causing NO limitations)
SLIGHT	(Tolerable, but causing a little limitation)
MODERATE	(Sometimes tolerable, but definitely causing limitations)
SEVERE	(Causing significant limitations)
EXTREME	(Causing near-constant [above 80% of the time] limitations)

What are you hoping the doctor tells you today?

Describe what you hope or think he can do for you.

If you cannot find a solution to this problem, what do you think will happen to you?

Due to your main problem...

Have you lost any time from work?	Yes	No
How much time and what tasks have been limited?	_____	
Have you lost time from your chores/tasks at home?	Yes	No
How much time and what tasks have been limited?	_____	
Have you lost any time from your family?	Yes	No
How much time and what tasks have been limited?	_____	
Have you lost any time from your leisure activities? (Hobbies, Sports, etc.)	Yes	No
How much time and what tasks have been limited?	_____	
Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe?		

About your MAIN PROBLEM; How often are you aware of this problem? (circle one)

Occasionally (25% of the time)	Intermittently (50% of the time)
Frequently (75% of the time)	Constantly (90-100% of the time)

How did you hear about us?

If you were referred to us, who should we thank?

Previous Health History

Have you had any Major Surgeries/Operations? If so, please explain.

Have you been diagnosed with any major diseases?

Have you had any major accidents or falls? If so, please explain.

What medications are you currently taking and what are they for?

Your Consent

Cancellation Policy: Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctor's day that could have been filled by another patient. As such, we require 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a cancellation fee to the card on file, up to 50% of the appointment charge.

I consent to allow the doctor to speak with me, perform an examination, take X-rays (if needed), and render recommended treatment. I have freely decided to undergo the recommended treatment(s), and hereby give my full consent to treatment. I also understand the clinic cancellation policy and give my full consent.

Patient Signature _____ Date _____

Parent/Guardian (for minor) _____ Date _____



1054 E Riverside Dr. STE 202
St. George, UT 84790
PH (435) 673-0900 FX (435) 359-5102

Consent for Treatment at Willow Bend Chiropractic

The Nature of Chiropractic Treatment: The Doctors of Chiropractic will use their hands or mechanical devices in order to move your joints. You may feel a “click” or “pop” such as the noise when a knuckle is “cracked” and you may feel the movement of the joint. Another treatment the doctor may recommend is cervical or lumbar decompression. Spinal decompression works by gently stretching the spine. This helps take pressure off of the discs between the bones in your spine. Various ancillary procedures, such as hot or cold packs and electric muscle stimulation may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include but are not limited to, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck, which could lead to nerve damage or death. A minority of patients may notice stiffness or soreness after the first few days of treatment. The possible side effects of spinal decompression include but are not limited to recurrent or continuing symptoms, blood clots, dural tear, leakage of cerebrospinal fluid, nerve injury and/or paralysis, and death. The ancillary procedures could produce skin irritation, burns or minor complications. Inform the doctor if you have a pacemaker.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

***** PLEASE CONTINUE TO THE NEXT SIDE AND SIGN! *****

Insurance Notice: I authorize my healthcare provider to collect, use, and disclose my personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the purpose of assessing my claims and administering the benefits of my plan. I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided. Willow Bend Chiropractic will do its best to assess my insurance eligibility and insurance benefits. I understand it ultimately remains my responsibility to understand my benefits if I opt to use my insurance plan for chiropractic care.

Cancellation Policy: Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the Practitioner's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee to the card on file, up to 50% of the appointment charge.

X-Rays: I authorize the performance of a diagnostic x-ray examination of myself which Willow Bend Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Females: REGARDING THE POSSIBILITY OF PREGNANCY: This is to certify that, to the best of my knowledge, I am not pregnant, and Willow Bend Chiropractic has my permission to perform a diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

I have read the explanation above of chiropractic treatment, spinal decompression, and possible side effects. If I have any further questions or concerns, I will consult the doctor. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment(s), and hereby give my full consent to treatment. I also understand the clinic cancellation policy and use of my personal information if I choose to have the clinic bill my health insurance and give my full consent.

PATIENT OR PARENT SIGNATURE: _____ DATE: _____

NAME: _____ DOB: _____

Notice of Privacy Practices

Willow Bend Chiropractic Effective Date: 12/3/2025

This Notice describes how your health information may be used and disclosed, and how you can access your information. Please review it carefully.

Our Commitment to Your Privacy

We respect your privacy and are committed to protecting your health information. Your records are created and maintained to provide quality care and comply with legal requirements.

How We May Use and Share Your Health Information

We may use or disclose your information for the following purposes:

Treatment: To provide, coordinate, or manage your care. This may include communicating with other healthcare providers involved in your treatment.

Payment: To bill and receive payment from you, an insurance company, or a third party. This includes verifying insurance benefits and submitting claims.

Healthcare Operations: For activities that support our practice, such as quality assessments, training, licensing, and auditing.

Family Members or Others Involved in Your Care: We may share information with individuals involved in your care when appropriate and permitted by law.

Required or Permitted by Law: We may disclose information when required by federal, state, or local law, including:

- Public health activities
- Reporting abuse or neglect
- Health oversight activities
- Court orders or legal proceedings
- Law enforcement

Workers' Compensation: We may release information for workers' compensation or similar programs.

Appointment Reminders and Follow-Up: We may contact you with reminders, treatment recommendations, or other health-related services.

Your Rights

You have several rights regarding your health information:

Right to Access: You may request to see or receive a copy of your records. We may charge a reasonable fee for copies.

Right to Amend: If you believe your information is incorrect or incomplete, you may request an amendment. If we deny the request, you may submit a statement of disagreement.

Right to Request Restrictions: You may request limits on how we use or disclose your information. While we will consider your request, we are not required to agree unless the restriction applies to services you paid for entirely out of pocket.

Right to Confidential Communications: You may request that we contact you in a specific way, such as a different phone number or mailing address.

Right to an Accounting of Disclosures: You may request a list of certain disclosures made in the past six years.

Right to a Paper Copy: You may request a paper copy of this Notice at any time.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your health information.
- Provide you with this Notice.
- Follow the terms of this Notice.
- Notify you if a breach of unsecured health information occurs.

We reserve the right to change this notice. Any changes will apply to all information we maintain. A current copy will always be available in our office and upon request.

Complaints

If you believe your rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. Filing a complaint will not affect your care.

Office Contact: Willow Bend Chiropractic 1054 E Riverside Dr, Suite 202 St. George, UT 84790 Phone: (435) 673-0900

Acknowledgment of Receipt

I acknowledge that I received a copy of Willow Bend Chiropractic's Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____